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On

VA Physician Compensation Issues

Presented by

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Good Afternoon. I am Thomas Lawley, M.D., dean of the Emory University School of Medicine. I am here this afternoon speaking on behalf of the Association of American Medical Colleges (AAMC). The AAMC represents the nation's 126 accredited allopathic medical schools, over 400 major teaching hospitals and health systems – including over 70 VA hospitals –, 92 academic and scientific societies representing nearly 100,000 faculty members, and the nation's medical students and residents. I currently also serve as chair of the AAMC's VA-Deans Liaison Committee, which provides a forum for medical school deans with strong VA affiliations to discuss important policy decisions with VA leadership.

The issue the subcommittee is debating today, reform of the VA physician compensation system, is an important one for both VA and academic medicine. Since the affiliation agreements began in 1946, the VA health care system has been intentionally intertwined with academic medicine, to the benefit of both parties. This relationship, by all counts, has been mutually beneficial, with VA gaining access to a higher quality of medical care than could be obtained with a wholly full-time VA medical service, and with the affiliated medical schools gaining valuable opportunities for medical education and research. The VA maintains approximately 8,600 full-time residency positions, and is the nation's largest provider of graduate medical education. However, that figure alone does not illustrate the full impact of the VA on academic medicine. Over 30,000 medical residents rotate through the VA system every year, in addition to over 20,000 medical students. And these figures do not even begin to address the other types of health professionals that provide services to, and receive educational training from, the VA.

Following the end of World War II, leaders of the Veterans Administration faced the problem of providing care to a large number of veterans while facing a shortage of qualified VA physicians. Simultaneously, medical schools were looking for ways to expand opportunities for graduate medical education to accommodate all the returning physicians who had gone into the armed services without completing specialty training.

Paul B. Magnuson, M.D., who chaired the department of orthopedic surgery at Northwestern University Medical School at the time, was one of the people called upon to help resolve this dilemma. He found that the VA shortage of physicians was caused in part by bureaucratic red tape and the poor reputation of VA medicine. Dr. Magnuson suggested that affiliations between medical schools and VA hospitals would solve VA's problem by allowing medical school deans to staff VA hospitals with top-notch medical school faculty physicians, residents and interns. The affiliated VA facilities, in turn, would provide medical schools with new venues in which to educate young physicians. Public Law 79-293, enacted on January 3, 1946, provided the legal basis for affiliating with schools of medicine, and established the VA Department of Medicine and Surgery, the predecessor of the Veterans Health Administration. Later that same month, VA published Policy Memorandum No. 2, the "Policy on Association of Veterans' Hospitals with Medical Schools." The memo made clear that the VA would retain full responsibility for the care of its patients, and the school of medicine would accept responsibility for all graduate education and training. The affiliations were intended to afford "the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service." Policy Memorandum No. 2 still guides the VA-medical school affiliations today.

The architects of the affiliations saw benefits in integrating the clinical care team at the VA with

the medical school and its teaching hospitals. This led to a construction policy of favoring sites near existing medical schools, and for the same reasons of cooperation and efficiency, medical schools often built facilities near existing VA hospitals. In fact, under the 1972 VA Medical School Assistance and Health Manpower Training Act, VA provided grants to expand existing medical education programs and facilities, as well as to establish five new medical schools (Marshall University, Wright State University, East Tennessee State University, Texas A&M University, and the University of South Carolina) for which the nearby VA medical centers would serve as their principal teaching hospital facilities. Such agreements led to the establishment of joint appointments and shared compensation for physician faculty, two hallmarks of the current affiliation agreements.

Under the current system, both full-time and part-time VA physicians receive additional salary from the medical school affiliate. Full-time physicians receive stipends for their contributions to the medical schools' educational programs. Part-time physicians receive salary for the academic portion of their appointment, but because the VA's physician compensation schedules have fallen so far short of market standards, a physician with a fractional VA appointment typically receives more than the proportionate share of his/her salary from the academic partner.

In recent years there has been growing concern that the physician compensation schedules in the VA health system have fallen even further behind the market. The recruitment of promising physicians to VA is often made possible only by the existence of a joint appointment at the academic affiliate. By accepting a joint appointment, individuals often receive research space and eligibility to apply for VA research funding. The VA also uses the joint appointment process as a recruiting tool, offering the opportunities (e.g., career advancement) afforded by an academic appointment as incentive for providing care at the VA. In fact, approximately 70 percent of VA physician staff members have some level of joint academic appointments, and some deans report the extent of joint appointments in their affiliations is over 90 percent. In addition to those with formal employment agreements, many full-time medical school faculty members maintain Without Compensation (WOC) appointments at the VA, which allow them to see and admit patients, educate medical students and residents, and conduct research within the VA medical center. Through such arrangements, the VA gains access to the full range of medical specialties and expertise that is generally available only at an academic medical center. In addition, interns and residents, supervised by attending physicians, participate in the care of countless veterans at VA medical centers.

Although it is unclear exactly how many full-time VA physicians with joint appointments receive stipends from the affiliated medical school, there is general consensus that without joint appointments, the VA would have difficulty recruiting and retaining physicians in the highest income specialties in virtually all locations. Part of the reason is that the amount of specialty pay has not increased since 1991, and cost of living and inflation increases for federal employees apply only to the base pay portion of the salary, meaning a VA physician's total compensation has been falling even further behind his/her private sector colleagues. As a result, there is anecdotal evidence that the agency is having difficulty and sometimes is unable to recruit and retain individuals in scarce specialties and subspecialties even with the academic salary subsidy. These difficulties are most severe in the disciplines with the highest pay disparities, such as certain surgical and medical subspecialties, radiology and anesthesiology.

This is a historic opportunity to implement a compensation system that is responsive to market forces. The proposal calls for a three-tiered approach that would be benchmarked to the 50th percentile of the AAMC's Associate Professor salary. It would incorporate performance-based pay as well as geographic, specialty, and productivity measures to bring VA's physician salaries in line with those in the non-federal workplace. VA estimates that such a change would increase the salary of approximately 30 percent of VA physicians at a cost of $124 million in the first year, and $636 million over 10 years when the savings from a reduction in contracts and fee-based services is taken into account. While such a change would certainly improve the VA's competitiveness in recruiting and retaining physicians in the highest paying specialties, the AAMC is concerned that the proposal does not go far enough. We believe that a system that benchmarks to the 75th percentile of the AAMC's Associate Professor salary level would better ensure that VA remains on the cutting edge of medicine and is able to compete for the best and brightest physicians. Such a change is estimated to cost an additional $244 million in the first year, and would increase salaries for over 99 percent of VA physicians. Implementation of such a proposal would significantly increase the ability of VA and the affiliate to recruit high quality physicians.

While the AAMC is supportive of the intent of the proposal to increase the salaries of VA staff physicians, we are concerned about provisions in the legislative language to prohibit VA Chiefs of Staff from receiving compensation of any type from the affiliate. Chiefs of Staff are the primary liaison between the VA and the medical school and, indeed, often hold the title of Associate Dean. It is essential that persons so appointed have academic credentials and credibility, as well as linkages with the affiliate. While I understand the VA's concern that Chiefs of Staff need to function as VA's independent representatives without conflicts of interest, limitations on the benefits and compensation that a Chief of Staff can receive from an academic affiliate will serve as a disincentive for the most qualified individuals to pursue such a leadership position. The ability to receive funds through NIH grants or for teaching or clinical work during non-VA time should be viewed as enhancing an individual's career, not a conflict of interest. Chiefs of Staff generally do not make business decisions for the VA; that is the responsibility of the Director, and conflicts of interest should already be covered by the Ethics in Government Act. Although it is my understanding that the proposed compensation prohibition would not affect a large number of Chiefs of Staff, the AAMC believes that the provision could be counterproductive and inhibit recruitment.

The VA academic affiliations have been a major reason that the VA health care system is a world leader. Since the affiliations began in 1946, mutually beneficial policies such as shared appointments and adjacent construction practices have provided the VA with access to the full range of high-quality medical care, and the affiliates with valuable education and research opportunities. The "Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003" will improve the ability of VA to recruit and retain the best and brightest physicians, and will result in better care for the nation's veterans through access to the latest clinical research and cutting edge technologies, as well as an enhanced academic environment.